Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health
on the
"Status of the Implementation of Public Law 107-287 and
VA-DoD Efforts to Coordinate Force Protection in the Active Duty Military
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March 27, 2003

Mr. Chairman, I am pleased to be here to testify before the Subcommittee on the "Status of the Implementation of Public Law 107-287 and VA-DoD efforts to coordinate force protection in the active duty military. With me today is Dr. Susan Mather, VA's Chief Officer for Public Health and Environmental Hazards. I will first address implementation of the provisions of Public Law 107-287.

Public Law 107-287 authorizes VA to furnish health care to victims during national disasters and emergencies declared by the President or when the National Disaster Medical System (NDMS) is activated. The law contains several other provisions intended to enhance VA's ability to identify, diagnose, respond to or prevent the medical consequences resulting from the use of weapons of mass destruction (WMD).

Implementation of the provisions of Public Law 107-287 has progressed more slowly than had been anticipated, due in large part to the uncertainty concerning language in VA's FY 2003 appropriations bill. Section 117 of H.R. 5605, as passed by the House, included language that would have prohibited the use of FY 2003 appropriations for implementation of all provisions of H.R. 3253, which was subsequently signed into law as Public Law 107-287. However, the

final language enacted on February 20, 2003, prohibited the use of funds provided for FY 2003 for implementation of only sections 2 and 5 of Public Law 107-287. Accordingly, VA is now actively pursuing implementation of the "non-prohibited" provisions.

Section 2

Section 2 authorizes VA to establish four medical emergency preparedness centers with a mission to carry out research, education, to develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological weapons posing threat to public health and safety. As discussed above, VA's appropriations act specifically prohibits any funds provided for FY 2003 from being spent on these centers. We continue to work with other agencies such as DoD, HHS, and DHS in our emergency preparedness role.

Section 3

Section 3 requires VA to carry out a program to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. That section further requires these programs to be modeled after programs established at DoD's Uniformed Services University of the Health Sciences and shall include, at a minimum, include emergency preparedness training for health care professionals. Their content must include, among other things, training in the recognition of chemical, biological, and radiological agents that may be used in terrorist activities and identification of potential symptoms related to use of those agents. The training would also be required to address short-term and long-term health consequences, including psychological effects that may result from exposure to such agents and the appropriate treatment of those health consequences.

The programs must be designed for a wide range of health care professionals at all levels. To date we have developed satellite broadcasts covering biological and chemical warfare issues as well as other educational

tools and programs for those who may be charged to render care for victims of terrorist incidents. Through our education infrastructure, we will share and disseminate these programs widely.

Involvement of education and training experts and representatives from involved disciplines/target groups is also essential as we continue to organize and develop a comprehensive education and training response. To this end, we have already held preliminary meetings with representatives from the Uniformed Services University of Health Sciences to explore collaborative endeavors. We intend to assemble a committee of experts to further develop a plan to address priority educational needs through the use of multiple modalities. In the meantime, we have conducted several excellent videoconferences on WMD produced by DoD; further, we taped those videoconferences to have training videos for future use.

Section 4

Section 4 authorizes VA to furnish health care to persons responding to, involved in or otherwise affected by (including veterans), major disasters and medical emergencies. Formal mechanisms for VA health care of DoD casualties have been in place since the 1980's.

Under § 8111A of title 38, United States Code, VA has a "fourth mission" - to serve as principal health care backup to DoD in the event of war or national emergency. Plans were developed jointly by VA and DoD to establish a VA/DoD Contingency Hospital System. An important objective of the planning effort is to assess VA's bed capacity to care for sick and wounded Armed Forces personnel in time of war or national emergency. VA medical centers assess five specific bed categories (Critical Care, Medical-Surgical, Psychiatry, Pediatrics, and Burn) required by DoD. Assessments take into account the impact on local operations of VA employees subject to mobilization.

VA's objective is to provide DoD with maximum bed availability in the specific contingency bed categories within 72 hours of activation of the VA/DoD Contingency Hospital System. VA may arrange care for some patients at civilian

community hospitals or through activation of the NDMS. Secondary Support Centers (SSCs) would provide backup to the Primary Receiving Centers (PRCs) by accepting transfers of patients or by providing staff and other resources. Fifty-eight VAMCs and three outpatient clinics have been classified as Installation Support Centers. The Installation Support Centers could assist a neighboring DoD installation or medical facility with clinical needs during a military mobilization.

A system is in place to recover the costs of health care provided to DoD beneficiaries in such events. Furthermore, VA is developing an implementation plan to establish and support the business requirements at all VA medical centers, including information technology changes and registration and billing requirements during and immediately following a disaster or emergency.

As to the NDMS, in 1997, VA signed a Memorandum of Understanding with the Federal Emergency Management Agency, Department of Health and Human Services, and DoD, continuing the NDMS partnership. One of the NDMS missions is to provide a civilian backup component to the VA/DoD Contingency Hospital System, if needed. This is accomplished through care at civilian hospitals enrolled in NDMS and allows for DoD casualties to be treated at these facilities when DoD and VA health care facilities reach capacity.

VA medical facilities regularly test and upgrade emergency response plans through training and exercises, including conducting quarterly bed reporting exercises of available staffed VA beds, as well as bed reporting exercises of available staffed NDMS-enrolled civilian beds.

In the aftermath of the September 11, 2001, attacks in this country, VA and DoD have partnered in many ongoing initiatives that focus on diagnosing and treating casualties of potential domestic terrorist events. Examples include VA-DoD exercises and training on casualty reception and care, jointly sponsored satellite broadcasts on weapons of mass destruction and DoD-hosted training for VA and DoD NDMS Federal Coordinators. In addition, VA's office of Policy, Planning and Preparedness interfaces with counterparts at DoD, HHS, and other agencies involved in national preparedness initiatives, and the VA-DoD Health

Executive Council Deployment Health Working Group regularly addresses issues of mutual concern and interest.

Section 5

Mr. Chairman, as stated above, VA may not use any of its FY 2003 appropriations to establish the new position of an Assistant Secretary overseeing operations, preparedness, security, and law enforcement functions. However, that has not precluded activities to ensure the protection of VA facilities, employees, and patients.

A security workforce of over 2,000 personnel, including police officers and detectives, currently protects VA medical and research facilities. Department security and law enforcement policy is established and overseen by the Office of Security and Law Enforcement (OS&LE). OS&LE has conducted numerous studies of security vulnerabilities and police officer staffing needs in the last twelve months. In addition, we are reviewing the findings of contracted vulnerability assessments and other data developed as a result of Public Law 107-188. As a result, we have taken the following actions.

- As part of the President's 2004 Budget Submission, VA has requested additional funds to fortify the Department's police force.
- We are developing a new Department-wide policy addressing personnel suitability and security screening requirements. The appropriate sections of the USA Patriot Act will be included this policy.
- OS&LE worked with a multi-agency work group and developed specific physical security requirements for research and clinical laboratories. These requirements were communicated to VHA field facilities and are checked for compliance during routine police program inspections. The requirements will also be included in the next revision of security policy.

Section 6

Section 6 was a codification of already existing authorities. These authorities focus on VA's ability to respond to a terrorist attack involving use of WMD that could occur in the community of any VA medical center.

VA has developed policies and directives that address the appropriate response to a WMD attack occurring nearby, but not directly on, a VA medical center. VA has also provided specific policy to VA facilities on the key steps required to implement an appropriate medical center emergency mass-casualty decontamination capability based upon local and community needs as part of a decontamination plan. The intent of those policies and guidelines are to protect the veterans, the facilities, and VA staff, and to provide appropriate care to victims of such an attack who may present at a VA medical center within 24 hours of an incident.

We have selected seventy-eight medical centers for implementation of VA's mass-casualty decontamination program during the next 12 months. These facilities have submitted a list of four core decontamination team members who will receive a one-week training course on decontamination operations and on how to provide the same training to the other decontamination team members at their facilities.

An inaugural VA Decontamination Training Course was held March 10-14, 2003 in Reno, Nevada. The week-long session offered three days of basic emergency hospital decontamination operations, and two days of a train-the-trainer program that gives trainees important skills to take back to their facility. Twenty-four staff from six VA medical centers completed the course. Subsequent training courses will be held at the Little Rock, AK and Bay Pines, FL VA medical centers.

Upon completion of the core-training program, facilities will be able to purchase the type and amount of decontamination units, and the personal protective equipment that they will need for their program. VA's Office of Acquisition and Materiel Management is currently soliciting vendors to supply this equipment. The core-training program includes guidance necessary to evaluate

and identify the range of equipment best suited to individual medical center needs.

VA has established an extensive system to deploy, track, and restock pharmaceutical caches to ensure resources are available to respond to chemical, biological, and radiological attack or other terrorist attacks, as well as respond to a WMD attack within the first 72 hours. VA uses delivery of pharmaceuticals through a centrally controlled tracking system of medical supplies, equipment, and pharmaceutical inventories. The pharmaceutical stockpiles at VA medical centers lessen the time required to obtain critical medical and surgical supplies from external caches such as the National Pharmaceutical Stockpile (NPS) or from usual procurement sources.

VA has developed strategies for providing mental health counseling and assistance, including counseling for Post-Traumatic Stress Disorder, to any individuals who seek care at VA facilities following bioterrorist attack or other public health emergency. In preparation for providing these services, VA provides training for VA staff and mechanisms for providing care in a coordinated fashion.

The best way to combat harmful emotional effects of such attacks is through providing accurate information to the affected population and through efficient coordination of response to the attack. The clinical mental health role involves accurate diagnosis to differentiate delirium due to the physical effect of an agent from acute stress reactions or psychotic states. It involves the recognition of acute stress reactions, other anxiety disorders, grief and bereavement, and depressive disorders. In the aftermath of an attack, most individuals should be expected to recover from acute emotional responses to the fear and stress of an attack. Clinicians must be alert, however, to detect those who have persisting symptoms of stress, anxiety, depression, and the risk of substance abuse in an attempt to deal with their symptoms.

Over the past several years, VA has created a number of satellite presentations on management of casualties from biological and chemical attack. In the first week of April 2003, VA will broadcast two satellite programs designed

to address management of possible casualties of the current war with Iraq. In addition, web-based materials will be made available to VA clinicians addressing both the physical and mental health aspects of war injuries. Issues of biological attacks will be included, since the skills required to deal with these types of injuries and issues in combat casualties are, in most cases, identical to those needed in response to a terrorist attack. We will, over the next weeks and months of 2003, train our mental health clinicians, using approaches acknowledged by our colleagues in HHS, DoD, and the American Red Cross to be most effective in managing response to terrorism. We will create in our Networks an infrastructure of trained clinicians, enduring educational materials, and local and national coordination to ensure that veterans, emergency responders, and others who come to VA for care in the event of a terrorist attack receive the help they need.

Mr. Chairman, I would now like to turn my attention to issues involved in force protection for the active duty military forces. Because nearly 250,000 U.S. troops are engaged in renewed conflict in the Gulf region, I am grateful for the opportunity to emphasize that VA today is better prepared to provide high quality health care and disability assistance than at any other time in our history. Since Operations Desert Shield/Desert Storm in 1991, VA has developed and implemented the following policies and programs in response to the lessons learned from that conflict.

Health Care, Surveillance, Education, and Outreach

Health Care following Combat

It is critical to provide informed, knowledge-based health care after every war. Congress has shown an appreciation for the importance of providing health care for combat veterans. Under 38 U.S.C. § 1710(e)(1)(D), added by Public Law 105-368, VA is authorized to provide health care for a two-year period to veterans who served on active duty in a theater of combat operations during a period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 1, 1998. Under this provision, veterans of

combat now have a two-year period of access to VA health care for any illness, regardless of whether there is sufficient medical evidence to conclude that the illness is attributable to that service. An exception to this general rule occurs when VA has found that a particular condition is not due to the period of service in question. Veterans of the current conflict with Iraq will be eligible for health care under this provision of law.

In addition to providing needed health care, VA has the capability to collect and analyze information on the health status and health care utilization patterns of veterans. The capability to collect this basic health information helps us evaluate specific health questions, such as determining the causes of difficult-to-explain symptoms experienced by some veterans returning from certain combat theaters or areas of hostilities. VA's medical record system now permits patient health information to be tracked for special groups of veterans. Moreover, standard health care databases allow VA to evaluate the health care utilization of veterans every time they obtain care from VA, not just on the one occasion that they elect to have a registry examination, as was the practice in the past. This will provide a much broader and longer-term assessment of the health status of these veterans because many veterans return frequently for VA health care and are often seen in different clinics or even different parts of the country for specialized health care.

Ensuring High Quality Post-Deployment Health Care

Specialized health care during the post-deployment period can help prevent long-term health problems. Therefore, VA has developed evidence-based clinical approaches for treating veterans following deployment. Newly developed Clinical Practice Guidelines (CPG's), which are based on the best scientifically supported practices, give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns. Two post-deployment CPG's have been developed in collaboration with DoD, a general purpose Post-Deployment CPG and a CPG for unexplained fatigue and pain. Our goal is that all veterans who come to VA will find their doctors to be well

informed about specific deployments and related health hazards. Information on Clinical Practice Guidelines are available online at www.va.gov/environagents. This web site also contains information about unique deployment health risks and new treatments.

Assessment of Difficult-to-Diagnose Illnesses

We have learned that sustained clinical care and research is needed to understand post-deployment health problems. Congress also understood this need and in legislation enacted as Public Law 105-368 required establishment of a plan to develop national centers for the study of war-related illness and post-deployment health issues. Subsequently, in 2002, VA established two such centers, known as "War-Related Illness and Injury Study Centers" (WRIISC's), in East Orange, NJ, and Washington, DC, to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult-to-diagnose but disabling illnesses. These centers are available through referral to veterans from all eras, including veterans of a future war with Iraq. These centers also provide research into better treatments and diagnoses, develop education programs for health care providers, and develop specialized health care programs to meet veterans' unique needs, such as the National Center for PTSD.

The majority of veterans returning from combat and peacekeeping missions are able to make the transition to civilian life with few problems. Most who come to VA for health care receive conventional diagnoses and treatments, and leave satisfied with their health care. Nevertheless, VA has learned that some veterans have greater problems on their return to civilian life, and a small percentage of them develop difficult-to-diagnose symptoms. The two WRIISC's focus on determining the causes and most effective treatments for difficult-to-diagnose symptoms -- problems seen in veterans of all wars. More information on the WRIISC's can be found at the VA website, www.va.gov/environagents.

Veterans Health Initiative

VA has built upon the lessons learned from our experiences with Gulf War and Vietnam veterans' programs to implement an innovative new approach to

health care for veterans. The Veterans Health Initiative (VHI) is a comprehensive program designed to increase recognition of the connection between military service and certain health effects, to better document veterans' military and exposure histories, to improve patient care, and to establish a database for further study.

The education component of VHI prepares VA healthcare providers to better serve their patients. We have completed modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, blindness/visual impairment and hearing loss, and radiation. We are currently developing modules on infectious disease health risks in Southwest Asia, sexual trauma, traumatic brain injury, and military occupational lung disease. These important tools are integrated with other VA educational efforts to enable VA practitioners to more quickly and accurately arrive at a diagnosis and to provide more effective treatment.

Enhanced Outreach

Outreach is critical, and the Gulf War made clear the value of timely and reliable information about wartime health risks for veterans and their families, elected representatives, the media, and the nation at large. VA has already developed a brochure that addresses the main health concerns for military service in Afghanistan and is preparing another brochure for the current conflict in the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these hazardous military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad.

Another challenge for outreach is to address the specific concerns of veterans and their families over the potential health impact of environmental exposures during deployment. Veterans also have questions about their symptoms and illnesses following deployment. These concerns are addressed through newsletters and fact-sheets to veterans covering health and compensation issues, including environmental health issues; regular briefings of

veterans service organizations; organization of national meetings on health and research issues; media interviews; other educational material and websites with information, like www.va.gov/environagents.

Recruit Assessment Program (RAP)

Based on the Department's experience providing health care and benefits to Gulf War veterans, VA recognizes the critical importance of health documentation and life-long medical records that cover pre-, during-, and post-deployment period. Previously, new health problems among Gulf War veterans were not readily verifiable due to a lack of detailed computerized records documenting enlistment and pre-deployment health status. Research efforts to understand Gulf War veterans' illnesses were also hampered by inadequate base-line health information, and inadequate documentation of health status during active duty.

DoD and VA have recognized these shortcomings and are attempting, through development and implementation of the Recruit Assessment Program (RAP), to collect comprehensive baseline health data from all U.S. military recruits. The RAP is a DoD program, which is under development with the support of VA. The goal is for the RAP to be the first module of a life-long health record for military personnel and veterans. The RAP will help DoD and VA to evaluate health problems among service-members and veterans after they leave military service, to address post-deployment health questions, and to document changes in health status for disability determination.

It is important to note that during the last two years all U.S. Marine Corps recruits initially trained on the West Coast have completed a RAP questionnaire as part of a pilot RAP development program. Therefore, baseline health data is available for over 31,000 Marines, many of whom are currently serving in the Gulf region.

VA Vet Center Program

VA's Vet Centers, originally conceived to provide a wide variety of readjustment services to Vietnam veterans, have been invaluable in providing similar services to veterans from more recent combat and peacekeeping

missions. More than 115,000 veterans of Operations Desert Shield/Desert Storm have made use of their services. We fully expect that the VA Vet Centers will be available to help both veterans of the current hostilities in Afghanistan and Iraq and veterans of future conflicts elsewhere in the world.

Disability Compensation

To assist in disability determinations, VA has actively worked with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits. VA has also worked to provide fair compensation for Gulf War veterans with difficult-to-diagnose illnesses. Under 38 U.S.C. § 1117 (as amended by Public Law 107-103), VA has authority to compensate Gulf War veterans for chronic disabilities resulting from an undiagnosed illness or certain medically unexplained chronic multisymptom illnesses. It is our belief that service members serving in the Southwest Asia Theater of Operations during the current conflict with Iraq would, as veterans, also be eligible for compensation for disabilities resulting from undiagnosed illnesses.

Coordination with the Department of Defense

Enhanced Interagency Collaboration

One of the important lessons learned from addressing Gulf War health issues was the need to significantly increase intergovernmental coordination among VA, DoD, and Department of Health and Human Services (HHS). The initial Government response to Gulf War veterans' concerns about their illnesses was not effectively coordinated among these Departments. As a consequence, the Persian Gulf Veterans Coordinating Board (PGVCB) was established in January 1994. This board, consisting of representatives from VA, DoD, and HHS, was created to coordinate Federal efforts in the areas of research, clinical care, and benefits. The initiation in 2000 of the tri-agency Military and Veterans Health Coordinating Board (MVHCB), replacing the PGVCB, served to

institutionalize future interagency cooperation. In 2002, the MVHCB was disbanded and a special deployment-health working group of the VA-DoD Health Executive Council was established to further its work and ensure continued interagency coordination for all veteran and military deployment health issues. Governmental coordination will continue to play a critical role in addressing health problems among veterans in future conflicts and peacekeeping missions.

Increased collaboration has also extended beyond America's borders and strengthened coordination with Military and Veterans Affairs agencies in other countries. On post-war health issues, such as those arising after Operations Desert Shield/Desert Storm, VA scientists and policy makers collaborate and share lessons learned with their counterparts in Canada, the United Kingdom, and Australia. Because of the similarity of health problems among war veterans of different countries, these collaborations have focused on difficult-to explain-symptoms that consistently arise among military personnel returning from hazardous deployments.

Transmission of Health Data between DoD and VA

VA and DoD are closely collaborating to develop the ability to share medical information electronically. Recently, the VA/DoD Joint Executive Council and Health Executive Council approved the adoption of the Joint VA/DoD Electronic Health Records Plan. This Plan provides for the exchange of health data and development of a common health information infrastructure and architecture supported by common data, communications, security and software standards, and high performance health information systems. Since June 2002, the Departments have successfully been sharing electronic medical information. Key initiatives in the Electronic Health Records Plan are the Federal Health Information Exchange (FHIE) and Health**e**People (Federal).

FHIE (formerly known as the Government Computerized Patient Record) provides historical data on separated and retired military personnel from the DoD's Composite Health Care System (CHCS) to the FHIE Data Repository for use in VA clinical encounters, and potential future use for aggregate analysis. Patient data on laboratory results, radiology reports, outpatient pharmacy

information, and patient demographics are now being sent from DoD to VA via secure messaging. This first phase of FHIE is fully deployed and operational at VA medical centers nationwide. The next phase is currently being deployed and includes admission discharge transfer data, discharge summaries, allergies, and consult tracking.

Health**e**People (Federal) is a strategy to achieve full interoperability among Federal health information systems, starting with the ability to provide a two-way exchange of health-related information between VA and DoD by 2005. VA and DoD are collaborating on several important health information applications in moving toward Health**e**People (Federal). Taken together, they will permit the Departments to offer a seamless electronic medical record.

- Clinical Data Repository/Health Data Repository (CHDR): This project seeks to ensure the interoperability of the DoD Clinical Data Repository with the VA Health Data Repository by FY 2005.
- Consolidated Mail-Out Pharmacy: The Departments are testing a system that allows VA to refill outpatient prescription medications from DoD's Military Treatment Facilities.
- Lab Data Sharing and Interoperability: VA and DoD are testing an application that will allow both Departments to combine resources and provide laboratory services to one another.
- Credentialing: A project team has identified common credentialing data to be exchanged between the DoD and VA. Software is being jointly developed and there are plans to begin testing at three sites by 4th Quarter FY 2003. This will decrease the time and resources needed to credential providers who need to practice in both health care systems.
- Scheduling: VA and DoD are sharing technical requirements to ensure interoperability between scheduling applications of each Department. This will allow providers to see all appointments a patient might have scheduled at both VA and DoD facilities and, where authorized, to schedule appointments in each other's clinics.

- E-portal Systems: The Departments are collaborating on a joint acquisition of health content for their electronic web portal systems. This will provide uniform patient health information to VA and DoD beneficiaries.

Deployment Health

VA applauds the efforts of DoD to prevent health problems among deployed troops and to provide immediate care for combat casualties. However, just as DoD has made substantial progress preventing morbidity and mortality on the battlefield, we also need to focus greater attention on the long-term health problems of veterans after the war. The trauma of warfare has lasting effects. The physical and psychological wounds of war can heal slowly, and toxic exposures on the battlefield may have enduring health consequences long after the actual war has ended.

The key to addressing the long-term needs of veterans is to improve medical record-keeping and environmental surveillance. To provide optimal health care and disability assistance after the current conflict with Iraq, VA needs the following:

- A complete roster of veterans who served in designated combat zones; and
- Data from any pre-deployment, deployment, or post-deployment health evaluation and screening of deployed troops.

Furthermore, in the event Iraq uses weapons of mass destruction against U.S. troops, it will be vital for VA to have as much health and environmental information as possible on potential exposures and their health effects in order to provide appropriate health care and disability compensation for veterans of this conflict. Ideally, information would be available from representative environmental samples, biological samples obtained from exposed troops, clinical data from exposed troops who seek medical care, and data from an epidemiological survey of symptoms and illnesses among potentially exposed troops.

Conclusion

Mr. Chairman, this concludes my statement. Let me say again that I am grateful for this opportunity to address the progress has made in implementing the provisions of Public Law 107-287 and to share with you the lessons we have learned to improve the programs and policies we have developed to be better prepared for U. S. service members returning from combat and peacekeeping missions overseas. Dr. Mather and I will now be happy to respond to any questions that you or other members of the Subcommittee might have.